USER ACCESS REQUEST

Fields outlined in RED are required fields

Request Date: _____ **Effective Date:** _____

Action: --Select One-- **Access:** --Select One--

NOTE: PDMP Access is only allowed to Prescribers, Dispensers and Dispenser's Designees

Facility/Location:

Employer: _____

Office Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Office Telephone: _____ **Office Fax:** _____

Contact Name: _____ **Contact E-Mail:** _____

User Information:

First Name: _____ **MI:** _____ **Last Name:** _____

Phone: _____ **E-Mail:** _____

***Direct Messaging Secure E-Mail Address (if applicable):** _____

Classification: --Select One--

If Other; please explain: _____

***NPI:** _____ ***DEA:** _____

Professional License Number: _____

***Specialty (i.e. Neurology, Orthopedics, etc.):** _____

***Local User ID (if applicable):** _____ ***Medicaid Provider:** ☐ **Yes** ☐ **No**

Work Group Administrator Signature (electronic or written): _____

*not required for DESIGNEE

PDMP Access Only:

If you are not a **DISPENSER**, please list the **DISPENSER** who is authorizing you as a **DESIGNEE:**

Dispenser Designator Name: _____

Dispenser Designator License Number: _____

If you are a **DISPENSER**, please list **DESIGNEE(s) and their LICENSE/REGISTRATION NUMBER(s)** you will be authorizing:

	Name (last, first MI)	License/Registration Number
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

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